Washington State Health Care Authority

5779 – Behavioral Health Integration

FAQ's and Comments

December 2017

1. What is the rationale for making a 6 month prior authorization requirement?
   In alignment with the model and the research it is based upon, the expedited prior authorization is required to ensure that:
   • Identified need to continue CoCM episode of care past initial 6 months
   • Client continues to improve as evidenced by improved score from a validated clinical rating scale
   • Targeted goals have not been met
   • Patient continues to actively participate in care

2. How long does the PA last? Another 6 months?
   Expedited prior authorization is required for the 6th month of service through the 12th month of service. Beyond 12 months prior authorization is required and will be reviewed based upon medical necessity criteria. For more information please see the Collaborative Care Model Guidelines in the Physician-Related Services Billing Guide

3. Does the required registry need to be embedded or connected to the Electronic Health Record (EHR) system?
   The registry is not required to be integrated or connected with the EHR. Information included in the Collaborative Care Core Principles section of the Physician-Related Services Billing Guide includes:

   A registry can be used in conjunction with the practice's electronic health records (EHR) if not built into it. The AIMS Center offers registry tools for use in conjunction with an EHR. Additional information is located in the AIMS Center Implementation Guide, Identify a Population-Based Tracking System.

4. Is the time duration for one encounter or accumulation of visits in one month?
   It is for the accumulation for the time in the month that the team contributes care that is documented. Use of the CoCM codes reflects time spent and not per encounter(s) or visit(s).

5. Did you identify the requirements for the BH provider in this model in addition to the medical provider?
   Yes. See Collaborative Care Model Guidelines in the Physician-Related Services Billing Guide for detailed information.

6. Is the CoCM model available for use by Behavioral Health providers in community Behavioral Health settings?
   No. CoCM is a medical model for a medical providers/practitioners. Should a Behavioral Health facility include a medical provider to provide this service the CoCM model could be used. It is not, however, a service billable by a Behavioral Health provider.

7. For FQHCs, G0512 is used for both the initial services and follow up services. How do we distinguish between initial and follow up which have different reimbursement rates?
   The HCA billing guide provides information on how FQHCs/RHCs should bill for this service. There is no coding requirement to distinguish initial from subsequent services. See Physician-Related Services Guide.

8. Can you clarify whether G0512 can only be billed once per month?
   This code is for 60 mins or more and is billed once per month per coding guidelines.

9. Does the G0512 qualify for FQHC/RHC encounter billing with code T1015?
   Per CMS guidance it does not qualify for the encounter rate/T1015.

10. May Physician Assistants (PA-C's) eligible providers of this service?
    PA-C's may provide the service under supervision of a physician (including FQHC/RHC settings). Billing for the service is per agency requirements and must be billed by the supervising physician or clinic.

11. Are you planning to also adopt G0511 and 99484?
    No, not at this time.

12. Are there credential requirements for the behavioral health care manager?
    No. the Behavioral health care manager is a designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the treating medical provider.

13. Can a licensed provider working in the CoCM model bill for services provided to a client receiving CoCM in the same month?
    Yes as long as the provider is enrolled with the agency and the service is within their scope of practice. The services would need to be distinctly different than what is provided as part of the collaborative care and the time spent on these activities for services reported separately may not be included in the services reported using time applied to 99492, 99493, 99494 and G0512.

14. Should the attestation be submitted for the facility/clinic or individual providing the service?
    If this is an individual billing provider in his/her own practice, then the attestation would be signed by them. If it's a group practice, it needs to cover all providers that are providing the collaborative care model and the indicator would be attached to the billing group.